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Postoperative Complications

TO THE EDITOR: I was of course saddened to read in my local newspaper about the unfortunate death of a patient after having had a hemorrhoidectomy performed. It is also unfortunate to read in the newspaper that physicians are being quoted that patients "never" die from the operation or after a hemorrhoidectomy.

The unfortunate fact is that patients can die after any kind of operation; even the most minor surgical procedures do have some morbidity and mortality. I believe that physicians should be very careful with words such as "never" or "always."

The complication of infection, which the patient I have mentioned suffered, is not unknown after rubber-band hemorrhoidectomy. As a matter of fact, this complication was discussed at a recent University of California postgraduate surgical program. One feels a great sympathy for the family and the patient and also for the attending physician. I write only to request that other physicians be very careful in the use of words such as "never" when they are questioned by the press about unfortunate surgical occurrences and postoperative complications. I have often thought that the loneliest man in the world is a surgeon whose patient has a postoperative complication.

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Some Less Obvious Causes of High Health Care Costs

TO THE EDITOR: There are several less obvious but nonetheless important causes of inflated health care costs that I, as the purchasing agent for my patients, should address and accept as my share of the responsibility for these costs. I will name three: respiratory therapy, coronary care units, intensive care units.

These ancillary hospital services are sometimes looked upon as fringe benefits of medical care, nice to have available, useful when needed and probably not too costly. Let us take a closer look.

Respiratory Therapy

In the mid-1960s there was an upsurge in respiratory therapy training programs. Before that time leg exercises, deep breathing, coughing and blow bottles had seemed to serve us well in preventing postoperative atelectasis and pulmonary emboli. But now, suddenly, I am remiss if I fail to order preoperative breathing exercises and the unit for the postoperative procedure given the title of "incentive spirometry."

All this has happened even though we have no documented evidence that such inhalation therapy is of any long-term benefit. In 1979 Dr John F. Murray editorialized as follows in the *New England Journal of Medicine:*

> No controlled studies have been performed to determine the prolonged influence of daily physiotherapy sessions of ventilation and gas exchange, the work of breathing and associated disability, and most importantly, the incidence of bronchopulmonary infections.

Looking at the bottom line, Blue Cross and Blue Shield are questioning whether the $4 billion paid out annually for respiratory therapy are dollars well spent. Should I, for my part, think twice before writing that "routine" order for inhalation therapy?

Coronary Care Units

Not too long ago coronary care units were found only in larger, metropolitan hospitals or teaching centers. Today every community hospital of even moderate size boasts of a CCU. These beautifully and expensively equipped units enclose the patient in a cocoon of electronic gadgetry, which beeps out the cardiac rhythms and disgorges endless strips of electrocardiographic tracings.

What a comfort to the patient to be constantly reminded that his most vital body functions are being closely monitored by this sophisticated machinery, and how reassuring for me to know that I am giving my patient the ultimate in medical care.

But is all this necessary? Just how much of this medical mothering is justifiable? One physician may insist upon 14 days in hospital for his coronary care patients, another follows a 10-day protocol, while still another is content with a 5-day stay. I am reminded of the Nottingham study in Great Britain reporting that relatively few patients with suspected myocardial infarcts are admitted to hospitals, yet their mortality statistics are comparable to ours. Who has the answer to this "big ticket" question?

Intensive Care Units

In the February 25, 1983, issue of *JAMA,* Hook and his associates reviewed the intensive care unit (ICU) statistics at Harborview Medical Center in Seattle.[1] They concluded that in pneumococcal bacteremia ICU support was of no benefit. They found, further, in reviewing earlier data, that the mortality and risk factors have not changed over the past two decades.

In the same issue of *JAMA,* Dr William Knaus editorialized, "To my knowledge, there is not a single scientific study claiming that, by itself, intensive care

Items submitted for the Correspondence section should be typed double-spaced (including references) with conventional margins. The text should not exceed 600 words.